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Commentary on Chronic Prostatitis/Chronic Pelvic Pain Syndrome: The Status Quo Is Not Good Enough (But It Can Be)

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ABSTRACT

Prostatitis is the name given to a group of disorders that share surprisingly little in the way of etiology, symptoms, and treatment. Frequently, the diagnosis and management of these conditions is empiric, inadequate, ineffective, and contrary to the published literature of the past 10 years. In the present commentary, 23 "theses" are presented as a plea to physicians managing these patients to modify their ingrained approaches and incorporate simple evidence-based changes that can greatly improve outcomes and patient quality of life.

COMMENTARY

In 1517, Martin Luther posted on the local church his 95 theses entitled, "Disputation on the Power and Efficacy of Indulgences." Luther was outraged that members of the Catholic Church were selling indulgences by telling parishioners that their sins would be absolved following payment. Well, 493 years later patients are coming to the "Church of Urology" with prostatitis, and in return for their pieces of silver they are often handed similar pieces of paper (antibiotic prescriptions) and told that they are absolved of their illness. Although I cannot comment on whether Renaissance-era indulgences bought their holders relief from temporal punishment in purgatory, the modern-day indulgences are not buying our patients relief from their punishment on Earth. Based on some published data and the histories of hundreds of patients I have seen with prostatitis, I believe that the typical standard of care ignores important published advances in our knowledge of diagnosis, classification, and therapy over the past 15 years. Enough is enough; we need a broad reformation of the medical community's management of these disorders. Here are my (fewer than 95) theses.

1. Stop telling everyone that they have *prostatitis* as though it is one disease. The National Institutes of Health (NIH) classification may not be perfect, but it is a start and simple to use [1]. Category I is an acute febrile urinary tract infection (UTI). Category II is recurrent UTI with the same bacteria that is recovered from the prostate between acute bladder infections. Category III is persistent pain with or without lower urinary tract symptoms (LUTS) in men without UTI who have no other demonstrable cause. Category IV is asymptomatic and found during semen analysis or prostate biopsy. Stop telling everyone that they have the same condition and treating them all the same.

2. You should not tell a man with pain between his nipples and knees that he has prostatitis without doing a proper history and physical examination.

3. Nobody has to do a full Meares-Stamey 4-glass test. Who cares if there is *Escherichia coli* in VB1 vs VB2? It makes no difference. You should test at least a midstream sample of urine and then obtain a culture of either prostate fluid or postmassage urine [2]. Unless you want false negatives, do

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Abbreviations and Acronyms

GU = genitourinary
LUTS = lower urinary tract symptoms
NIH = National Institutes of Health
PSA = prostate-specific antigen
UTI = urinary tract infection

the test after the patient has been antibiotic-free for at least 2 weeks.

4. Do you think that doing a prostate massage and getting some fluid is difficult and time consuming? It is not. If you cannot do it, get a postmassage urine sample instead.

5. Just because the patient complains of pain during a rectal exam, it does not mean that they have prostatitis.

6. While your finger is in the rectum, palpate the muscles to either side of the prostate. If they feel rock hard or if the patient reacts and says, "That is my prostate pain," then the patient has pelvic floor spasm. At least half of men with category III prostatitis have this condition [3], and it can get better with pelvic floor physical therapy [4]. This is NOT a subtle finding; if you look for it, you will easily find it.

7. Not everyone with prostatitis needs a cystoscopy. However, if you do a cystoscopy, stop telling patients that their prostate has the "classic appearance of prostatitis." There is no such thing.

8. If the patient has true category II chronic bacterial prostatitis, do not give them 5 days of antibiotics. They need 2-4 weeks of antibiotic medication [5]. Advise the patient of potential side effects (eg, tendinitis with quinolones, sun sensitivity with tetracyclines, diarrhea with any antibiotic).

9. Do not try to eradicate category II prostatitis with nitrofurantoin. It does not penetrate the prostate [6].

10. Everyone is busy; many men have a simple urethritis and a few have UTI. It is alright to give a course of antibiotics empirically the first time. However, if it does not work and cultures are negative, STOP GIVING THEM.

11. Just because a patient feels a bit better on antibiotics and feels worse the day after stopping them does not mean that he has an infection. Quinolones, macrolides, and tetracyclines are powerful anti-inflammatory drugs that block cytokines directly [7]. These antibiotics kill bacteria in the prostate for up to 2 weeks, so if the patient has pain the day after stopping them but does not have a fever, IT IS NOT AN INFECTION.

12. The normal prostate is not a sterile place. It has been reported that 68% of healthy men have gram-positive bacteria in their prostate fluid, and 8% of healthy men have classic *uropathogens* [8]. Every bacteria found on culture is not necessarily the cause of symptoms, especially if appropriate treatment does not improve the symptoms.

13. Do not treat men who have pelvic pain with empiric interstitial cystitis therapies unless their symptoms actually suggest bladder involvement (eg, severe refractory frequency; pain that worsens with bladder filling and improves with emptying) [9].

14. Do not forget to tell men about simple and often effective supportive measures such as sitting on a donut-shaped cushion and avoiding caffeine and spicy foods.

15. Consider using a clinical phenotyping system to stratify patients for therapy, such as the one found at http://www.upointmd.com. This website gives a complete, simple algorithm for the diagnosis and multimodal therapy of chronic pelvic pain syndrome (CPPS) [10].

16. Learn and use simple and effective therapies for the different clinical domains:

- Urinary symptoms: alpha blockers or antimuscarinics
- Prostate pain or inflammation: quercetin [11] and cernilton [12]
- Systemic neurologic symptoms: pregabalin or amitriptyline [13]
- Pelvic floor spasm: pelvic floor physical therapy (myofascial release, NOT Kegel's) [4]

17. Patients with longstanding chronic pain can get depression and feel helpless or hopeless. This reaction is called *catastrophizing* [14]. Find out if they are feeling these emotions with a few simple questions and refer those with symptoms to other professionals for treatment.

18. Help patients to be optimistic, because most will eventually get better. Do not tell them that this is a condition they will have until the day they die.

19. Take new symptoms seriously. Patients with prostatitis also can develop kidney stones and genitourinary (GU) cancers.

20. In patients without UTI, do not treat an elevated prostate-specific antigen (PSA) with antibiotics to see if the PSA will drop. The PSA may drop but the cancer risk does not [15].

21. Use the NIH Chronic Prostatitis Symptom Index to monitor symptom severity, but NOT to diagnose the condition [16].

22. Prostate consistency varies among men. Having an isolated finding of a "boggy prostate" is meaningless and does not diagnose prostatitis or any other condition.

23. Assemble a good referral team. Urologists cannot be expected to treat the parts of these conditions that do not pertain to the GU system. Team members may include physical therapists who know myofascial release therapy, pain management specialists, and psychologists who have experience with catastrophizing, chronic pain, or stress.

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